

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09455

Reg. Dist. No.

9460

1. PLACE OF DEATH a. COUNTY <b>QUEEN ANNE'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CENTREVILLE</b>				c. LENGTH OF STAY IN 1b <b>50 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ralph Callaway Baynard</b>				4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1887</b>	9. AGE (If years lost birthday) yrs. <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM OWNER</b>		11. BIRTHPLACE (State or foreign country) <b>FARMINGTON, DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Emmett Baynard</b>				14. MOTHER'S MAIDEN NAME <b>LAURA BELL CALLAWAY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-34-9641</b>		17. INFORMANT Address <b>RISDON E. BAYNARD, QUEENSTOWN, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Aug 4, 1958</b> to <b>Aug 11, 1958</b> that I last saw the deceased alive on <b>Aug 11, 1958</b> , and that death occurred at <b>10:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. S. McThurmon</b> M.D.				DATE SIGNED <b>Centreville Md</b>			
PHYSICIAN'S NAME (Type) <b>H. E. McThurmon</b>				ADDRESS <b>Centreville Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Aug. 14, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Centreville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Butler Jr. of Baltimore, Centreville, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Thoms</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09456

9461

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHURCH HILL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHURCH HILL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		e. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) <u>VAN</u> First <u>GASKEN</u> Middle <u>CLARK</u> Last <u>SR.</u>		4. DATE OF DEATH Month <u>AUG.</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 27-1902</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>OLIVER CLARK</u>		14. MOTHER'S MAIDEN NAME <u>SALLY DULIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Mrs. Van Clark Church Hill Md.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug 1, 1958</u> to <u>Aug 6, 1958</u> , that I last saw the deceased alive on <u>Aug 6, 1958</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. F. McPherson</u>		ADDRESS (Street, city or town, state) <u>Centerville Md.</u>	
PHYSICIAN'S NAME (Type) <u>H. F. McPherson</u>		DATE SIGNED <u>8/7/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug. 4</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgard Lane</u>		ADDRESS <u>Church Hill Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09457

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u>		c. LENGTH OF STAY IN 1b <u>ALL LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Embert</u> Last <u>Cook</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14 1895</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>RURAL CENTREVILLE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Thomas Cook</u>				14. MOTHER'S MAIDEN NAME <u>MARY V. EMBERT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-0327</u>		17. INFORMANT <u>William H. Cook, CENTREVILLE, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Found dead in kitchen &amp; had</u> <u>4344</u> DUE TO <u>been dead for 6 days — He had had</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>heart disease &amp; short winded for some time</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Sept. 6, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chester Field Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>CENTREVILLE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Buttrick, of Buttrick Bros., Centerville, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 8 1958</u>		24b. REGISTRAR'S SIGNATURE <u>WILLIAM E. HARRIS</u>	





9463

CERTIFICATE OF DEATH

09458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crumpton</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crumpton</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> <b>C.</b> <b>DIXON</b>				4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January, 24, 1891</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Dixon</b>				14. MOTHER'S MAIDEN NAME <b>Anna Shahan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-28-2197A</b>		17. INFORMANT <b>Mrs. Myrtle Dixon, Crumpton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension -</b> (c) <b>Atherosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>3 years</b> <b>4-5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 9, 1955</b> to <b>Aug 9, 1958</b> , that I last saw the deceased alive on <b>Aug 6, 1958</b> , and that death occurred at <b>7:41 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MILLINGTON, MD</b> DATE SIGNED <b>8.10.58</b> ACTUAL SIGNATURE <b>GEORGE KORALEWSKI</b> M.D. PHYSICIAN'S NAME (Type) <b>GEORGE KORALEWSKI</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 13, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Millington Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Millington, Kent Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows, Millington, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

10440

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>John Dixon</b>		2. SEX <b>Male</b>		3. AGE <b>65</b>	
4. DATE OF DEATH <b>Jan 15 1944</b>		5. TIME OF DEATH <b>10:30 AM</b>		6. PLACE OF DEATH <b>Home</b>	
7. CAUSE OF DEATH <b>Heart Disease</b>		8. DISEASE OR INJURY <b>Coronary Artery Disease</b>		9. MANNER OF DEATH <b>Natural</b>	
10. SIGNATURE OF PHYSICIAN <b>Dr. J. H. Smith</b>		11. SIGNATURE OF WITNESSES <b>Dr. J. H. Smith</b>		12. SIGNATURE OF DECEASED <b>John Dixon</b>	
13. SIGNATURE OF REGISTRAR <b>John Dixon</b>		14. SIGNATURE OF CLERK <b>John Dixon</b>		15. SIGNATURE OF JURY <b>John Dixon</b>	
16. SIGNATURE OF JURY <b>John Dixon</b>		17. SIGNATURE OF JURY <b>John Dixon</b>		18. SIGNATURE OF JURY <b>John Dixon</b>	
19. SIGNATURE OF JURY <b>John Dixon</b>		20. SIGNATURE OF JURY <b>John Dixon</b>		21. SIGNATURE OF JURY <b>John Dixon</b>	
22. SIGNATURE OF JURY <b>John Dixon</b>		23. SIGNATURE OF JURY <b>John Dixon</b>		24. SIGNATURE OF JURY <b>John Dixon</b>	
25. SIGNATURE OF JURY <b>John Dixon</b>		26. SIGNATURE OF JURY <b>John Dixon</b>		27. SIGNATURE OF JURY <b>John Dixon</b>	
28. SIGNATURE OF JURY <b>John Dixon</b>		29. SIGNATURE OF JURY <b>John Dixon</b>		30. SIGNATURE OF JURY <b>John Dixon</b>	
31. SIGNATURE OF JURY <b>John Dixon</b>		32. SIGNATURE OF JURY <b>John Dixon</b>		33. SIGNATURE OF JURY <b>John Dixon</b>	
34. SIGNATURE OF JURY <b>John Dixon</b>		35. SIGNATURE OF JURY <b>John Dixon</b>		36. SIGNATURE OF JURY <b>John Dixon</b>	
37. SIGNATURE OF JURY <b>John Dixon</b>		38. SIGNATURE OF JURY <b>John Dixon</b>		39. SIGNATURE OF JURY <b>John Dixon</b>	
40. SIGNATURE OF JURY <b>John Dixon</b>		41. SIGNATURE OF JURY <b>John Dixon</b>		42. SIGNATURE OF JURY <b>John Dixon</b>	
43. SIGNATURE OF JURY <b>John Dixon</b>		44. SIGNATURE OF JURY <b>John Dixon</b>		45. SIGNATURE OF JURY <b>John Dixon</b>	
46. SIGNATURE OF JURY <b>John Dixon</b>		47. SIGNATURE OF JURY <b>John Dixon</b>		48. SIGNATURE OF JURY <b>John Dixon</b>	
49. SIGNATURE OF JURY <b>John Dixon</b>		50. SIGNATURE OF JURY <b>John Dixon</b>		51. SIGNATURE OF JURY <b>John Dixon</b>	
52. SIGNATURE OF JURY <b>John Dixon</b>		53. SIGNATURE OF JURY <b>John Dixon</b>		54. SIGNATURE OF JURY <b>John Dixon</b>	
55. SIGNATURE OF JURY <b>John Dixon</b>		56. SIGNATURE OF JURY <b>John Dixon</b>		57. SIGNATURE OF JURY <b>John Dixon</b>	
58. SIGNATURE OF JURY <b>John Dixon</b>		59. SIGNATURE OF JURY <b>John Dixon</b>		60. SIGNATURE OF JURY <b>John Dixon</b>	
61. SIGNATURE OF JURY <b>John Dixon</b>		62. SIGNATURE OF JURY <b>John Dixon</b>		63. SIGNATURE OF JURY <b>John Dixon</b>	
64. SIGNATURE OF JURY <b>John Dixon</b>		65. SIGNATURE OF JURY <b>John Dixon</b>		66. SIGNATURE OF JURY <b>John Dixon</b>	
67. SIGNATURE OF JURY <b>John Dixon</b>		68. SIGNATURE OF JURY <b>John Dixon</b>		69. SIGNATURE OF JURY <b>John Dixon</b>	
70. SIGNATURE OF JURY <b>John Dixon</b>		71. SIGNATURE OF JURY <b>John Dixon</b>		72. SIGNATURE OF JURY <b>John Dixon</b>	
73. SIGNATURE OF JURY <b>John Dixon</b>		74. SIGNATURE OF JURY <b>John Dixon</b>		75. SIGNATURE OF JURY <b>John Dixon</b>	
76. SIGNATURE OF JURY <b>John Dixon</b>		77. SIGNATURE OF JURY <b>John Dixon</b>		78. SIGNATURE OF JURY <b>John Dixon</b>	
79. SIGNATURE OF JURY <b>John Dixon</b>		80. SIGNATURE OF JURY <b>John Dixon</b>		81. SIGNATURE OF JURY <b>John Dixon</b>	
82. SIGNATURE OF JURY <b>John Dixon</b>		83. SIGNATURE OF JURY <b>John Dixon</b>		84. SIGNATURE OF JURY <b>John Dixon</b>	
85. SIGNATURE OF JURY <b>John Dixon</b>		86. SIGNATURE OF JURY <b>John Dixon</b>		87. SIGNATURE OF JURY <b>John Dixon</b>	
88. SIGNATURE OF JURY <b>John Dixon</b>		89. SIGNATURE OF JURY <b>John Dixon</b>		90. SIGNATURE OF JURY <b>John Dixon</b>	
91. SIGNATURE OF JURY <b>John Dixon</b>		92. SIGNATURE OF JURY <b>John Dixon</b>		93. SIGNATURE OF JURY <b>John Dixon</b>	
94. SIGNATURE OF JURY <b>John Dixon</b>		95. SIGNATURE OF JURY <b>John Dixon</b>		96. SIGNATURE OF JURY <b>John Dixon</b>	
97. SIGNATURE OF JURY <b>John Dixon</b>		98. SIGNATURE OF JURY <b>John Dixon</b>		99. SIGNATURE OF JURY <b>John Dixon</b>	
100. SIGNATURE OF JURY <b>John Dixon</b>		101. SIGNATURE OF JURY <b>John Dixon</b>		102. SIGNATURE OF JURY <b>John Dixon</b>	

RECEIVED JANUARY 17 1944

10440



9464

CERTIFICATE OF DEATH

09459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>QUEEN ANNE'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL STEVENSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x RURAL STEVENSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>R.</b> Middle <b>Mildred</b> Last <b>Mitchell</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 10, 1874</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REGISTERED NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>QUEENSTOWN, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Joseph Brown Mitchell</b>		14. MOTHER'S MAIDEN NAME <b>Georgia Emory</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>C. Mitchell Davidson</b>		Address <b>Stevensville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of r. breast about 170 x</b> DUE TO (b) <b>Metastases generalized in chest &amp; abdomen</b> DUE TO (c) <b>cholecystectomy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mastectomy r breast Aug. 1957</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 years ago</b> <b>1 year</b> <b>84 years ago</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>At</b>		20f. (City or town) (County) (State) <b>Stevensville Md.</b>	
21. I certify that I attended the deceased from <b>Aug. 12, 1958</b> , to <b>Aug 13, 1958</b> , that I last saw the deceased alive on <b>Aug 12, 1958</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Theodor Sattelmaier</b>		ADDRESS (Street, city or town, state) <b>Stevensville Md.</b>	
DATE SIGNED <b>Aug 14, 1958</b>			
PHYSICIAN'S NAME (Type) <b>Theodor SATTELMAIER, M.D.</b>		<b>STEVENSVILLE, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Aug. 16, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Old Wye Church</b>	22d. LOCATION (City, town, or county) (State) <b>Wye Mills, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Boring, Jr. of Boring Bros., Centerville, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 18 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy of the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3464

DECEASED Name: <i>John A. Smith</i> Date of Birth: <i>1912</i> Sex: <i>Male</i> Race: <i>White</i> Marital Status: <i>Married</i> Occupation: <i>Teacher</i> Usual Residence: <i>1234 Main St., Baltimore, Md.</i> Date of Death: <i>1968</i> Place of Death: <i>Home</i> Cause of Death: <i>Heart Disease</i> Manner of Death: <i>Natural</i> Physician: <i>Dr. J. B. Jones</i> Burial Place: <i>Greenwood Cemetery</i> Date of Burial: <i>1968</i> Name of Undertaker: <i>John Doe</i> Signature of Registrar: <i>[Signature]</i> Date of Registration: <i>1968</i> County: <i>Baltimore</i> State: <i>Md.</i>	
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9465

## CERTIFICATE OF DEATH

Reg. Dist. No.

09460

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Stevensville</u>				c. LENGTH OF STAY IN 1b <u>8 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Stevensville</u>			
				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank Joseph Novak</u>				4. DATE OF DEATH Month Day Year <u>August 3 19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1897</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Novak</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hajek</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Dorina Novak Stevensville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>Aug.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug. 2</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.				ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt</u>				DATE SIGNED <u>8/3/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 5</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Kane</u>				ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 6 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. S. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove correct papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9466 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09461

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u>			c. LENGTH OF STAY IN 1b <u>6 WKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>PATE</u> Last <u>PATE</u>				4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 16, 1910</u>	
9. AGE (If years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK - BOOKKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>MOUNT VERNON, ILLINOIS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN GRIFFITH PATE</u>				14. MOTHER'S MAIDEN NAME <u>MARY EMMA McCLEAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>346-07-1721</u>		17. INFORMANT <u>MRS LOLA PATE - wife - CENTREVILLE Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>  <u>420.1</u> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u>            DUE TO (c) <u>  </u> </p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		Month, Day, Year <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug. 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>CENTREVILLE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler, Jr. of Butler Bros. Centerville, Md.</u>				24a. RECEIVED BY REGISTRAR DATE <u>SEP 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9467

## CERTIFICATE OF DEATH

Reg. Dist. No. 09462

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Millington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Millington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>DAVID</b> First <b>F.</b> Middle <b>WADDELL</b> Last <b>SR.</b>				4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1892</b>		9. AGE (In years last birthday) <b>66</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Refrigeration Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Ref. Eng.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles G. Waddell</b>				14. MOTHER'S MAIDEN NAME <b>Martha Steward</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>148-01-921</b>		17. INFORMANT <b>David F. Waddell, Jr.</b>		Address <b>Millington, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Alcohol Poisoning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Chronic Myocarditis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Myocarditis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Aug 29, 1958</b> , to <b>Aug 30, 1958</b> , that I last saw the deceased alive on <b>Aug 29, 1958</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David F. Waddell, Jr.</b>				DATE SIGNED <b>Sept 1, 1958</b>			
PHYSICIAN'S NAME (Type) <b>Dr. F. Waddell, Jr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 1, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Crumpton, Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Crumpton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>				24a. REC'D BY REGISTRAR <b>SEP 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove certain parts. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAVJAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9468

## CERTIFICATE OF DEATH

Reg. Dist. No.

09463

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POND TOWN</u>		c. LENGTH OF STAY IN 1b <u>POND TOWN - RURAL CHESTERTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN</u> <u>WASHINGTON</u>		4. DATE OF DEATH Month Day Year <u>AUGUST</u> <u>16</u> <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 16, 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>GEORGE WASHINGTON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>EMMA WASHINGTON</u>		Address <u>RURAL MD. CHESTERTOWN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen. Arterio Sclerosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Several years</u> <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>None</u> <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that I attended the deceased from <u>Aug 2</u> , 19 <u>58</u> to <u>Aug 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 2</u> , 19 <u>58</u> , and that death occurred at <u>5-30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Hamilton</u>		ADDRESS (Street, city or town, state) <u>Mullington Md.</u>	
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>		DATE SIGNED <u>8/13/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>POND TOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward H. H. HAMILTON</u>		ADDRESS <u>Mullington Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Hance</u>	





## CERTIFICATE OF DEATH

Reg. Dist. No.

09464

9469

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) <u>Burton</u> First <u>Wilson</u> Middle <u>Wilson</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/178</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATER MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oystering</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u> (If yes, give war or dates of service) <u>XX</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Ms. Carrie Manning, Chester Md.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>Aug</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 25</u> , 19 <u>58</u> , and that death occurred at <u>7 30</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Queenstown, Md</u> DATE SIGNED <u>9/2/58</u>			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.		PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester Vein</u>	22d. LOCATION (City, town, or county) <u>Chester Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doherty, Easton Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 3 1958</u> DATE _____	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

